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# The Secret Life of the Dominant Form of Managed Care: Self-Insured ERISA Networks

Charles D. Weller

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# THE SECRET LIFE OF THE DOMINANT FORM OF MANAGED CARE: SELF-INSURED ERISA NETWORKS

*Charles D. Weller\**

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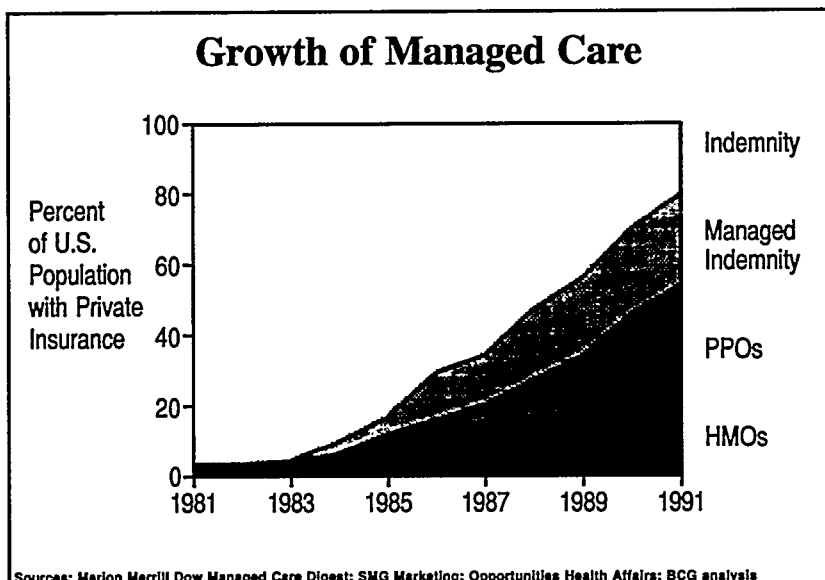
## I. INTRODUCTION: THE "TWO ROADS" OF MANAGED CARE

"**MANAGED CARE**,"<sup>1</sup> as the accompanying "Growth in Managed Care" chart<sup>2</sup> graphically shows, began about fifteen years ago, and has been accelerating since the early 1990s:

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1. See generally ROBERT W. MCADAMS ET AL., *MANAGED CARE CONTRACTS MANUAL* (1996), and part V, *infra*. This Article elaborates on some of the subjects covered in Charles D. Weller, *Health Care and Antitrust Policy at the Crossroads: Dangers and Opportunities* (Nov. 1995 paper submitted to Fed. Trade Comm'n Hearings on Competition Policy in the New High-Tech, Global Marketplace) [hereinafter Weller, *Crossroads*].

2. BOSTON CONSULTING GROUP, *THE CHANGING ENVIRONMENT FOR U.S. PHARMACEUTICALS* 18 (1993).



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It is driving the most profound and revolutionary change in health care history, as incisively explained by Judge Melloy in his Dubuque, Iowa hospital merger antitrust opinion:<sup>3</sup>

Traditionally, hospitals competed on the basis of amenities and perceptions of quality. Only in the last ten to fifteen years have hospitals begun to compete on the basis of price. To a large degree, this competition has occurred because of the arrival of managed care.

Today, innovation and change in health care approaches that of the personal computer and credit card markets, and the past is not a prologue for the future.

Managed care, however, is new and only at the "Model T" stage. Like the Model T, it has unleashed a private revolution. The Model T, after all, was revolutionary in its day for consumers and horseless carriage companies — and horse and buggy manufacturers. As Judge Melloy pointed out, for the first time in the history of American health insurance, large doses of provider cost, price, quality, and service competition are being applied because of managed care. Cost reimbursement and Usual Customary and Reasonable (UCR) fees for

3. *United States v. Mercy Health Serv.*, 902 F. Supp. 968, 973 (N.D. Iowa 1995). See also Bryan Gruley & Laurie McGinley, *Rebuke in Dubuque*, WALL ST. J., Jan. 4, 1996, at 1-A.

providers have largely gone the way of the buggy whip. In Antitrust 101 terms, there has been de facto deregulation of the health care field, particularly in the last five years.<sup>4</sup>

One type of managed care, Health Maintenance Organizations (HMOs), is well known. HMO enrollment, which is concentrated in California and a few other states, has doubled, from about twenty-five to fifty million, in the last ten years.<sup>5</sup>

What is not so well-known, indeed it almost seems to be a secret, is a second type of managed care: self-insured ERISA (Employee Retirement Income Security Act) networks.<sup>6</sup> This second type of managed care, including self-insured Preferred Provider Organizations (PPOs), are the dominant form of managed care because of at least four factors: sheer numbers, rate of growth, legal regulatory flexibility, and antitrust flexibility.

Self-insured employee plans of all types cover about 100 million people and pay over \$100 billion a year in benefits of all types.<sup>7</sup> As the chart shows, PPO networks alone (1) cover more people than HMOs, (2) have grown faster than HMOs, and, (3) particularly important today, the self-insured ERISA variety have much more legal flexibility than state-regulated HMOs and insurance companies.<sup>8</sup>

As to antitrust flexibility, self-insured ERISA networks took on even greater importance starting December 5, 1995. On that date, Mark Whitener, the Deputy Director of the Federal Trade Commission's (FTC) Bureau of Competition, announced in a speech that the FTC has begun focusing on "the needs of employers who offer self-funded health benefits plans," which means the FTC will consider new ways to encourage provider networks *without* "capitation and similar risk sharing."<sup>9</sup> As a matter of antitrust law and policy, the federal

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4. See, e.g., Supreme Court Justice Stephen Breyer's classic on the subject, STEPHEN BREYER, *REGULATION AND ITS REFORM* (1982) [hereinafter BREYER, *REGULATION*]. See also STEPHEN BREYER, *BREAKING THE VICIOUS CIRCLE* (1993) and CHARLES SCHULTZE, *THE PUBLIC USE OF PRIVATE INTEREST* (1977).

5. See, e.g., MARION MERRILL DOW, *MANAGED CARE DIGEST: HMO EDITION-1994* (1995).

6. See parts II and VI, *infra*, for details.

7. See part II, *infra*.

8. Congress deliberately chose to subject ERISA plans to market regulation rather than government regulation for most matters. See part III, *infra*.

9. Mark Whitener, Deputy Director, Federal Trade Commission, *Antitrust, Medicare Re-*

antitrust agencies are likely to apply mainstream antitrust law and thus less restrictive views that will unleash new competition by provider networks to serve self-insured health plans, without the current legally unnecessary and impractical capitation, risk-sharing, and "pure" messenger requirements.<sup>10</sup> Self-insured ERISA networks, in addition, have added antitrust protection and flexibility because of the National Cooperative Research and Production Act of 1993 (NCRPA),<sup>11</sup> which now is being applied to the health care field without risk-sharing potentially regulable by the state.<sup>12</sup>

Self-insured plans are profoundly different from HMOs in a number of ways,<sup>13</sup> but two often overlooked differences are particularly noteworthy: premiums and state regulation. First, HMOs and insured plans have premiums; self-insured plans do not. Thus, self-insured plans have no cash reserves from which to pay capitation to providers: no premium, no cash for capitation.

Second, HMOs and insured plans are subject to state regulation; self-insured ERISA plans largely are not.<sup>14</sup> Ironically, the current push by state insurance and other government regulators to increase regulation of managed care and capitated plans is likely to have the opposite effect:<sup>15</sup> the more regula-

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*form and Health Care Competition*, Remarks 16 (Dec. 5, 1995).

Note: This Article was written before the FED. TRADE COMM'N AND DEPT OF JUST., STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE was published in August 1996.

10. See part VI, *infra*.

11. 15 U.S.C. §§ 4301-4306 (1994).

12. Charles D. Weller et al., *NCRPA Spells Immediate Antitrust Relief for Health Care Providers*, 5 HEALTH L. REP. (BNA), at 1433 (1996).

13. There are other profound differences, including: (1) standardized benefit packages are unnecessary, since the self-insured pool is not broken up and thus manipulating benefit plan terms and exclusions to increase profits or reduce costs is never an issue; (2) adverse selection is not an issue for the same reason; (3) no annual enrollment is necessary, since patients select providers when they need them rather than annually when they select their HMO, and because a self-insured plan's insurance pool is not broken up; (4) Primary Care Physicians (PCPs) and gatekeeping need not be added to the benefit plan, thus avoiding difficult union negotiations for union plans; avoiding a "take away" issue for most employees and their families, and allowing physicians to practice together as teams; (5) "mature markets" are two-dimensional rather than one, since all roads do not lead to HMOs; there is a second self-insured road; and (6) self-insured ERISA networks can focus on *marketing* to customer needs, rather than *selling* what federal and state law and regulators allow HMOs to sell. Marketing, rather than selling, is a key tenet of modern management. See, e.g., PETER DRUCKER, *MANAGEMENT* 64 (1973). See also part VI, *infra*.

14. See part III, *infra*.

15. See part III, *infra*. Antitrust and economic history are filled with examples of increased

tion, the more incentive there is to become or stay self-insured.<sup>16</sup> Indeed, the more states try to regulate HMOs and capitation, the more likely and quickly both will become like buggy whips, the "wave of the past," rather than the "wave of the future."

Accordingly, contrary to the conventional wisdom, managed care is likely to evolve along two roads, HMOs and self-insured plans, rather than one road with HMOs as the final destination. The two roads diverge over premiums and state regulation: one road, the HMO/capitation road, has premiums and state regulation; the second road leads to self-insured ERISA plans, which have no premiums and basically no state regulation. Indeed, there appears to be an Achilles heel in the common assumption that HMOs and capitation will become widely used: state regulation and premiums.

This Article explores the second, less well-known road: self-insured ERISA networks. Self-insured ERISA networks are not the road less travelled, they are simply the road less known. Self-insured ERISA networks have the legal flexibility and sheer numbers to lead rather than follow the move from the current "Model T" generation of managed care to the next generation, likely to be known by a new and more patient-friendly phrase like "patient choice."

## II. THE END OF INSURANCE AND THE RISE OF SELF-INSURANCE

### A. Overview of Health Insurance Coverage in the United States

Overall, U.S. health insurance coverage, and noncoverage, breaks down approximately as follows:<sup>17</sup>

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government regulation providing incentives for innovators to find ways to escape government regulation, and of regulated businesses and regulators cooperating to try to prevent or hobble new competition. *See generally* FREDERIC M. SCHERER & DAVID R. ROSS, *INDUSTRIAL MARKET STRUCTURE AND ECONOMIC PERFORMANCE* (3d. ed. 1990).

16. As discussed in part III, ERISA preemption is strongest for self-insured plans.

17. *See, e.g.*, HEALTH INS. ASS'N OF AM., *SOURCE BOOK OF HEALTH INSURANCE DATA—1994* 33 (1995) [hereinafter *HIAA SOURCE BOOK*]. However, health care is plagued by the same data problems faced by most fields in the midst of revolutionary change. *See, e.g.*, JOSEPH W. DUNCAN & ANDREW C. GROSS, *STATISTICS FOR THE 21ST CENTURY* (1995); Christina

150 million-Employee health plans  
30 million-Medicare (primarily over age 65)  
20 million-Medicaid (primarily the poor)  
15 million-Private individual coverage  
35 million-Uninsured  
250 million-Total

The single largest source of health insurance coverage in the United States, in terms of people covered, is employment-based. About 160 million people, two-thirds of the population, are covered through public and private employment. Employee health plans cover about 150 million people as active employees, plus another ten million retirees with Medicare Supplement benefits, and the dependents of both.<sup>18</sup>

The average cost of employee health plan coverage is about \$4000 per year per employee (including dependents).<sup>19</sup> For self-insured plans, about ninety-five percent is paid for health benefits, and five percent is paid to third-party administrators (TPAs). For HMOs and fully insured plans, about eighty-five percent goes to health benefits and fifteen percent to the insurer or HMO.

Of the payments to health care providers, about half are for hospital care, twenty-five percent for physician care, and twenty-five percent for other services:

25%—hospital inpatient  
25%—hospital outpatient  
25%—physician & other professionals  
25%—drugs, lab & other

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Duff, *Government Statistics: Good Riddance to Bad Rubbish?*, WALL ST. J., Nov. 17, 1995, at B1; *OMB Releases New Industry Classification System for Public Comment*, DAILY LAB. REP. (BNA), at A-7 (July 26, 1995) (new SIC codes finally issued to replace SIC codes dating to the 1930s). Nonetheless, the conclusions reached here are sound even within large ranges. For example, self-insured ERISA networks are very important, whether they cover 50 million or 100 million people.

18. Of the 30 million or so people with Medicare coverage, the "40-30-15-15" Rule applies. About 40%, or 12 million, have Medicare Supplement benefits as a result of employment, 30% buy individual Medicare Supplements (a/k/a Medigap policies), 15% are covered by Medicaid, and about 15% have no Medicare supplemental coverage. Interview with Dr. Gail Wilensky in Cleveland, Ohio, Dec. 1995. From a legal point of view, Congress chose the ERISA deregulation model for employee Medigap plans, and a state and federal regulatory approach to individual Medigap policies.

19. See, e.g., *Employee Health-Care Costs Decline*, CLEV. PLAIN DEALER, Feb. 14, 1995, at 1-C.



(These numbers are order of magnitude, and can vary substantially in individual cases).

## B. The End of Insurance and the Rise of Self-Insurance

A chart similar to the "Growth in Managed Care" chart above could be drawn for the same time period charting the decline of "insured" health plans, and the rise of "self-insurance."

In the early 1980s, employee health plans began shifting dramatically from fully insured health insurance to various forms of self-insurance. Today, of the 160 million people with employee plan coverage, about 100 million are covered by self-insured plans.<sup>20</sup>

"Self-insurance" includes a number of financial arrangements:<sup>21</sup>

1. *No Insurance*, where the employee plan is totally at risk for all health claims.

2. *Stop-Loss Insurance*, where the employer or health and welfare plan is insured for catastrophic cases above a certain stop-loss amount. There is no insurance below these stop-loss limits, which is where the vast majority of claims fall.

3. *Minimum Premium Insurance*, which is similar to stop-loss insurance.

4. *HMO Prepayment*. As noted earlier, about fifty million people are enrolled in HMOs. In theory, HMOs are fully insured plans. In practice, some have developed "self-insured" products to be competitive, and some state regulators have permitted this competitive practice.

Why the switch to self-insurance? The principal reason for employee health plans switching to "self-insurance" was to save state premium taxes of about three percent.<sup>22</sup> In today's dollars, these savings are substantial. Employee health plans save on the order of three billion dollars (three percent of \$100 billion).

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20. HIAA, SOURCE BOOK, *supra* note 17, at 38.

21. *Id.* at 4-5, 14, 190, 195.

22. Patricia McDonnell et al., *Self-Insured Health Plans*, HEALTH CARE FIN. REV., Winter 1986, at 1; EBRI, QUESTIONS AND ANSWERS ON HEALTH INSURANCE BENEFIT ISSUES (Aug. 1995); 12 PENS. & BEN. REP. (BNA), at 1326 (Sept. 30, 1985).

### III. ERISA PREEMPTION AND LEGAL FLEXIBILITY

#### A. Introduction

The differences in legal regulation between self-insured ERISA plans, HMOs, and insured plans often is misunderstood or ignored, but it is critical. Today, approximately 100 million people in public and private employee health plans are in "self-insured" plans, with most in health plans covered by ERISA. The difference in legal flexibility, and thus the opportunity for congressionally intended private innovation to occur for tens of millions of people in self-insured ERISA plans is hard to overstate.

#### B. Substantive and Procedural Flexibility

In 1975, Congress passed ERISA, among other things, to deregulate employee health and welfare plans, and broadly to preempt state laws that relate to employee benefit plans. Basically, although there are exceptions, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."<sup>23</sup>

There are two important dimensions to ERISA preemption, substantive and procedural. First, substantively, ERISA's preemption of state law has been broadly construed, particularly for self-insured plans.<sup>24</sup> Second, procedurally, the U.S. Supreme Court has determined that many disputes involving state law and benefits do not have to be litigated in state court. They can be removed to federal courts and litigated there.<sup>25</sup>

As a practical matter, this means that self-insured ERISA plans, the single largest form of health coverage, and the doctors, hospitals, carriers and others that serve them, can act quickly, like personal computer makers and software companies, with a minimum of state and federal regulation and red tape.

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23. 29 U.S.C. § 1144(a) (1994).

24. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding insurance company that insured a benefit plan entitled to ERISA preemption of all plaintiff's state law claims). See also *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding self-insured plans are *not* subject to "indirect" state insurance regulation, e.g., mandated benefit laws; insured plans are); *New York Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995) (finding no preemption has encouraged a flurry of state regulatory activity).

25. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

HMOs and insured plans do not enjoy the same legal flexibility. To illustrate, Ohio Revised Code Chapter 1742 and 42 CFR, Part 417, are the tip of the regulatory iceberg with which federally qualified HMOs in Ohio must comply. *None* of these complex regulations apply to self-insured ERISA plans. Moreover, *no other state's* red tape applies in any of the other states where employee plans and their labor union agreements, if any, provide health benefits.

Although some argue that Congress should not have exempted employers and employees from 1000 state-mandated benefit laws and other varying and conflicting regulations and costs, as discussed next, Congress carefully considered these issues and chose ERISA preemption. Since many companies operate nationally, this means they and their labor unions, as applicable, can experiment with and lead private health care innovation with a minimum of red tape. That is exactly what they were doing for the first time in history, beginning just a few years ago.

### C. Any Willing Provider Laws

One of the important current issues relating to ERISA preemption is whether ERISA preempts state "Any Willing Provider" (AWP) laws when applied to HMOs, or insured plans, or self-insured plans.<sup>26</sup> In earlier days, they were referred to as "open panel," "anti-closed panel," "free choice," and "mandatory provider" laws.<sup>27</sup>

Ultimately, the Supreme Court should find ERISA pre-

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26. See, e.g., *Cigna Healthplan of La. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996) (holding ERISA preempts Louisiana's AWP law); *Prudential Ins. Co. v. Texas Pharmacy Ass'n*, 907 F. Supp. 1019 (W.D. Texas 1995) (holding ERISA does not preempt Texas' AWP pharmacy law), *aff'd as modified*, 105 F.3d 1035 (5th Cir. 1997) (holding ERISA preempts current, but not prior, statute); *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 114 S.Ct. 579 (1993) (no preemption of Virginia's AWP law for insured plans).

Interestingly, a 1972 pre-ERISA case by the Supreme Court of Washington held that an any-willing-optometrist law was unconstitutional under the contract and due process clauses. *Ketcham v. King County Med. Serv. Corp.*, 502 P.2d 1197, 1214 (Wash. 1972).

On the McCarran-Ferguson Act, which sometimes is relevant to interpreting ERISA preemption, see generally Charles D. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L. J. 587 (1978).

27. See generally Charles D. Weller, *Free Choice as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351 (1984).

emption for both prepaid and self-insured plans, based on the language, history, and purpose of the law and earlier Supreme Court rulings.

Both the House and Senate sponsors of ERISA, Representative Williams and Senator Javits, expressly stated that state laws of any kind that restricted the use of closed-panels, or that mandate open-panels, would be preempted by ERISA. This legislative history should make clear that ERISA preempts state open-panel laws for insured (prepaid) and uninsured plans.

Senator Williams is frequently quoted by the Supreme Court<sup>28</sup> for the proposition that Congress intended ERISA preemption to be broad:

It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulation, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.<sup>29</sup>

Significantly, Senator Williams cited the specific example of the type of state law ERISA was intended to preempt in his very next sentence, the "closed panel," AWP-type laws:

Consistent with this principle, State professional associations acting under the guise of State-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized — for example, prepaid legal services programs — whether closed or open panel — by Public Law 93-95.

Similarly, Senator Javits made clear, on the same day, that ERISA preempts state laws that restrict closed panel plans:

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28. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).

29. 120 CONG. REC. 29933 (1974); 3 SUBCOMM. ON LABOR OF THE SENATE COMM. ON LABOR AND PUBLIC WELFARE, 93D CONG., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, at 4745-46 (1976) [hereinafter ERISA LEGIS. HISTORY].

[T]he State, directly or indirectly through the bar, is preempted from regulating the form and content of a legal service plan, for example, open versus closed panels, in the guise of disciplinary or ethical rules or proceedings.<sup>30</sup>

Thus, although the Supreme Court's 1995 *N.Y. Blues* case has been interpreted by some eager state regulators and legislatures to allow extensive AWP and other regulation of ERISA managed care plans,<sup>31</sup> it is likely that the Supreme Court will rule that AWP laws are preempted by ERISA for self-insured and "prepaid" plans, based on the language, history, and purpose of the Act and the Court's precedent, coupled with the adverse impact on employee plans.

#### IV. SELF-INSURED PLANS AND CAPITATION: NO CASH

Capitation and other forms of risk-sharing are little used in self-insured plans today because of numerous legal and business reasons, discussed in more detail below. These same reasons make it unlikely capitation ever will be widely used by the self-insured plans that cover on the order of 100 million people and pay more than \$100 billion annually in benefit payments.

##### A. Cash Flow

As noted earlier, in self-insured plans there are no premiums. Bills are paid from the employee health plan's bank account, not from insurance company or HMO funds. The cash involved in paying the bills for the 100 million people in self-insured health plans totals about \$100 billion annually. Why would employee plans be willing to lose the cash flow and pay \$100 billion to providers, in advance, in twelve monthly installments? Thus, cash flow reasons alone make a major shift to capitation unlikely.

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30. 120 CONG. REC. 15757 (1974); ERISA LEGIS. HISTORY, *supra* note 29, at 4789 (emphasis added).

31. See, e.g., *National Anti-Managed Care Laws Would Raise Health Costs, Study Says*, MANAGED CARE REP. (BNA), at 7 (July 5, 1995).

## B. ERISA Preemption of 1000 State Mandates

If capitation is "insurance," then employee health plans will lose ERISA preemption, and be subject to more than 1000 state-mandated benefit laws. Not many plans want be involved in litigating the issue, or losing it.

## C. Premium Tax Savings

Similarly, if capitation is "insurance," then the employee health plan may be subject to state premium taxes of, all told, about three billion dollars annually. Again, few employee health plans are willing to take this dollar or litigation risk.

## D. State and Other Regulation

In August 1995, the staff of some state insurance departments strongly recommended that capitation and other risk-sharing arrangements be regulated as the "business of insurance."<sup>32</sup>

As a matter of law, this interpretation seems overzealous and unlikely to be sustained by the courts. It has long been the law that the mere transfer of risk is not enough to establish "insurance." As former insurance law professor, now judge, Robert Keeton incisively explained, "all insurance contracts concern risk transference, but not all contracts involving risk transference are insurance."<sup>33</sup>

Furthermore, there are legal uncertainties regarding risk-sharing under various Medicare and Medicaid laws. For example, on December 1, 1994, new rules were proposed that impose penalties for certain physician incentive plans that induce physicians to *reduce* care and thus reduce costs.<sup>34</sup> Similar

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32. See, e.g., *Overwhelming Opinion of NAIC Group That Provider Networks be Licensed*, 4 HEALTH L. REP. (BNA), at 1264 (Aug. 17, 1995). For the full text, see MCADAMS ET AL., *supra* note 1. See also GROUP HEALTH ASS'N OF AM., PHOS AND THE ASSUMPTION OF INSURANCE RISK (July 10, 1995); *Georgia: PHO To Change Health Contract Clarifying That It Is Not Insurer*, 4 HEALTH L. REP. (BNA), at 1042 (July 6, 1995); Md. 90 Op. Att'y Gen. 030 (June 19, 1990) (ruling certain provider risk-sharing arrangements to be the business of insurance).

33. ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW* 12 (1988). This also is not a new issue. See *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205, 225-30 (1979).

34. See 59 Fed. Reg. 61,571 (Dec. 1, 1994).

rules restricting physician incentive plans, including risk-sharing, apply to HMOs.<sup>35</sup>

Thus, there are several legal uncertainties, and regulators who take the position that capitation and risk-sharing are the "business of insurance," ironically, make capitation and risk-sharing more risky, less desirable, and thus less likely, and make self-insurance more desirable.

### E. Adverse Selection

"Adverse selection" or "cream skimming" occurs when the capitation payment is too high for a healthy person and too low for somebody who is sick. The General Accounting Office (GAO) recently issued a number of reports on the adverse selection problem for Medicare's capitation program. The GAO reported that the Medicare capitation program costs Medicare at least \$500 million a year, and perhaps as much as \$2.5 billion, because of adverse selection.<sup>36</sup>

In short, it is technically difficult (some argue it is technically impossible) to develop individual capitation rates that eliminate adverse selection risks, thus creating another disincentive for self-insured employee health plans to use them.

### F. Macro Versus Micro

Employers and employee health plans generally operate at a "macro" level of total, annual budgeted costs rather than at the "micro" level of capitated, "Per Member Per Month" or "PMPM" ratings. Their cost focus is "What were total health benefit costs last year, and what are they going to be this year?"

Further, employee plans generally have little experience,

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35. See 59 Fed. Reg. 36,072 (July 15, 1994).

36. U.S. GEN. ACCT. OFFICE, No. T-HEHS 95-174, MEDICARE MANAGED CARE: PROGRAM GROWTH HIGHLIGHTS NEED TO FIX HMO PAYMENT PROBLEMS 7, 13 (May 24, 1995); U.S. GEN. ACCT. OFFICE, No. HEHS 96-21, MEDICARE MANAGED CARE: GROWING ENROLLMENT ADDS URGENCY TO FIXING HMO PAYMENT PROBLEM (Nov. 1995). See, e.g., *Medicare HMO Rates: Voodoo Methodology?*, HEALTH POL'Y WEEK, Apr. 11, 1988, at 1; Wynand P.M.M. van de Ven et al., *Risk-Adjusted Capitation*, HEALTH AFF., Winter 1994, at 120; Joseph P. Newhouse, *Rate Adjusters for Medicare Under Capitation*, HEALTH CARE FIN. REV., Supp. 1986, at 45; Gerard F. Anderson et al., *Paying for HMO Care: Issues and Options in Setting Capitation Rates*, 64 MILBANK Q. 548 (1986).

interest, or capability to deal at the "micro" level of capitation. Indeed, many employers I know have had bad experiences with HMO "cream skimming." Many employers also recently had to deal with the "micro" level of PMPM to comply with FAS 106, a new accounting standard for retiree medical benefits.<sup>37</sup> The task was time-consuming, costly, and of little or no ongoing management value.

Finally, "cream skimming" makes it hazardous to the health (and career) of a benefits manager to go from the "macro" level they know to the "micro" level they usually do not.

### G. Controversial Incentives

Capitation arguably gives providers incentives not to provide needed care.<sup>38</sup> Judge Richard Posner recently described these "perverse incentives" in the HMO context: "the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible."<sup>39</sup> These quality concerns, as well as potential bad publicity and increased legal risks, also chill interest in capitation and risk-sharing.

### H. Fifteen Percent Versus Five Percent

Most self-insured health plans' administrative costs are in the neighborhood of five percent. Employee health plan executives read newspapers, and see profit margins on the order of fifteen to twenty percent by HMOs and other capitated plans. Why not keep the ten percent difference for the employee health plan?

### I. No Proof It Works

Even though HMOs and capitation have been around for more than fifty years, HMOs and other capitated plans today

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37. See, e.g., William H. Steinbrink & Charles D. Weller, *Volatile Accrual: What You Need to Know About FAS 106*, MGMT. REV., May 1993, at 59.

38. See, e.g., *Cover Story: The Soul of an HMO*, TIME, Jan. 22, 1996, at 44.

39. *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995), *cert. denied*, 116 S.Ct. 1288 (1996).



and for years have varied widely in their performance as to total costs, utilization, and premiums.<sup>40</sup> Many employee health plans have recently experienced better cost performance with their self-insured networks than with HMOs. In short, there is little or no proven correlation between capitation and performance.

### J. National Versus Local

Employers and unions, if applicable, generally desire uniform benefits in all their locations nationally. HMOs and insured plans cannot deliver these uniform benefits, because each state's laws vary and ERISA does not preempt state mandated benefit laws for insured plans. It does for self-insured plans.

### K. MIS Limitations

Capitation, risk-sharing, and withholds may be nice to have in theory, but they cannot be administered by many existing computer systems. The reality is that very few TPAs or carriers have the Management Information System (MIS) capability to handle capitation, withholds, or risk-sharing.

### L. Complexity

The administrative complexity of paying different capitation rates that adjust risk for age, sex, location, and other factors is another major impediment to widespread use by employee health plans.

These complexities are illustrated by a typical capitation contract:

Capitation Payment. On or before the tenth (10th) day of each month, Network shall pay Physician the applicable capitation payment below for the provision of Capitated Services to each Covered Person who has selected Physician, based on the age and sex of each Covered Person as actuarially determined by the Network:

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40. See, e.g., MARION MERRILL DOW, *supra* note 5; Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make With Physicians*, 333 N. ENG. J. MED. 1678 (1995).

<i>Age</i>	<i>Male</i>	<i>Female</i>
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

These capitation rates apply when the Covered Person's benefit plan requires a \$5.00 copayment for each office visit. In the event that a different copayment amount applies, the capitation rates may be adjusted by the Network.<sup>41</sup>

Different benefit plans also require different capitation rates. In the HMO world, there are a relatively small number of benefit plans. In the self-insured or collective bargaining world, there often are dozens of different benefit plans. Indeed, one of my clients had 275 different benefit plans! Furthermore, it is rarely easy or inexpensive to change or consolidate benefit plans, for example, changes may be subject to collective bargaining.

Taxes are another example of the practical complexities involved. What is the withhold taxable income to the provider? Who keeps track of the thousands of "eighty/twenty" splits so that accurate and timely Form 1099s can be issued? Who earns interest on the withhold? When is it payable? Who makes sure the interest is in a 1099?

In short, capitation is much more complicated for employers to administer than self-insured plans already in place and operating.

### M. Small Dollars: Who Cares?

Outside the few areas where HMOs are concentrated or where there is a large payer, risk-sharing has a serious "who cares?" problem. In many markets, no single payer accounts for enough business to affect physician practice patterns. To illustrate:

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41. AM. ACAD. OF HOSP. ATT'Y, MANAGED CARE HANDBOOK 53-83 (1993).

**Physician Revenue by Payer****Percent of Revenue from Selected Sources, by Region, 1992<sup>42</sup>**

<u>Payers</u>	<u>Medicare Patients</u>	<u>Medicaid</u>	<u>Blue Cross/ Blue Shield</u>	<u>Other Third-Party Payers</u>	
All Physicians	27	10	17	30	16
Northeast	28	9	20	27	17
North Central	27	10	19	30	14
South	27	10	17	29	18
West	24	10	15	35	17

Thus, in many markets no single payer matters enough for withholds really to work and change physician behavior.

Moreover, physician services account for about twenty-five percent of employee health plan costs. Thus, a twenty-percent withhold of physician services at most puts at risk five percent of total employee plan costs (twenty percent of twenty-five percent). Who cares?

In summary, there is little or no capitated or risk-sharing business actually in place today in self-insured plans, and little if any reason for this to change much in the future.

## V. THE MANAGED CARE REVOLUTION

### A. Evolution

The "Growth in Managed Care" chart shows that health benefits have been in the midst of the most important and profound private market changes in history.

The 1980s were basically a decade when employers and their benefit consultants tried to "fix" indemnity plans by imposing co-insurance and deductibles. For various reasons, these "fixes" did not work. By the end of the decade, a new ap-

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42. AM. MED. NEWS, Aug. 2, 1993, at 21.

proach was needed desperately because employee plan costs returned to double-digit inflation.

In the early 1990s, employee plans and benefits consultants made a paradigm shift to "managed care," a shift that has been accelerating ever since. Rather than continuing to try to "fix" indemnity plans, they shifted to using private incentives for cost, quality, and performance with hospitals and other providers — selective contracting with networks of providers. With the paradigm shift to selective contracting networks, cost reimbursement, Usual, Customary, and Reasonable (UCR), and billed charge pricing in most cities is dead or dying as a practical matter.<sup>43</sup>

The "Growth in Managed Care" graph shows that these private market changes have occurred with breathtaking speed and scope (it has continued apace since 1991 when the graph stops). To illustrate, in the early 1990s I surveyed twelve major Cleveland businesses that provide health benefits to 350,000 Clevelanders and 1.5 million people nationally. By 1992, all had done something they had never done before — adopted and were implementing some form of "managed care" plan and were dropping traditional indemnity coverage.

## B. Various Definitions of Managed Care

There is no legal, standard, or generally accepted definition of managed care. Instead, "managed care" encompasses all of the following:<sup>44</sup>

### 1. *Health Maintenance Organizations*

HMOs are primarily state-regulated companies that, traditionally, combine insurance with a closed panel of providers.<sup>45</sup>

HMOs are concentrated in a few states, with about half of all HMO enrollees found in just five states:

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43. See, e.g., *Employee Health-Care Costs Decline*, CLEV. PLAIN DEALER, Feb. 14, 1995, at 1-C (showing a 76% enrollment in managed care among large employers in northeast Ohio); *Employers Cut Health Costs in 1994, Shift to Managed Care, Survey Finds*, 22 PENS. & BEN. REP. (BNA), at 487 (Feb. 20, 1995) (showing a 63% enrollment in managed care nationally).

44. See, e.g., HIAA, SOURCE BOOK, *supra* note 17, at 21-51.

45. See generally MCADAMS ET AL., *supra* note 1.

**Five States With The Largest HMO Enrollment<sup>1</sup>**  
(In Hundred Thousands)

State	Pop'n	HMO Enrollment		Cumulative	
		No.	%	No.	%
1. California	30,797	11,216	36%	11,216	23%
2. New York	17,886	4,656	26%	15,872	33%
3. Florida	13,915	2,549	18%	18,420	38%
4. Mass.	5,985	2,329	39%	20,750	43%
5. Texas	17,391	2,325	13%	23,074	47%
U.S.	251,987	48,782	19%		

<sup>1</sup>Marion-Merrill-Dow, *Managed Care Digest: HMO Edition - 1994*, at 16-17.

The traditional HMO benefit design was “all or nothing”: generous benefits if the patient used the closed panel of providers, no benefits if the patient did not. Financing was exclusively by premium, or “prepayment” in the HMO vernacular.

HMOs have changed dramatically over the last twenty years. Originally, Kaiser was the model HMO — vertically integrated companies which owned their own hospitals and employed their physicians.<sup>46</sup> Now only about forty percent of all HMO enrollees, twenty million people, are in group or staff model HMOs.<sup>47</sup> Further, in reality, a significant amount of HMO business is self-insured rather than prepaid.

It is customary, although not conceptually consistent or discriminating, to count all enrollees of legally licensed HMOs as HMO enrollees. That is, any person covered by an entity licensed by a state as an HMO is counted as an HMO enrollee, whether prepaid or self-insured, and whether having a group,

46. See, e.g., George Anders, *In Age of the HMO, Pioneer of the Species Has Hit a Rough Patch*, WALL ST. J., Dec. 1, 1994, at A1; Ron Winslow, *Employer Group Rethinks Commitment to Big HMOs*, WALL ST. J., July 21, 1995, at B1 (suggesting that Minneapolis, widely perceived as the HMO model of the future, is moving away from HMOs and towards the provider joint ventures that are emerging in the self-insured world around the country).

47. MARION MERRILL DOW, *supra* note 5, at 4.

staff, network, or other arrangement with providers. Other than the common legal bond of state licensure, HMOs vary widely in what they do and how they operate. Using the legal definition of an HMO under state law, there are about fifty million people enrolled in HMOs.

As a practical matter, HMO enrollment is significantly less than fifty million in two ways. First, a significant number of HMO enrollees are self-insured, not prepaid. They should be counted not as HMO enrollees, but as self-insured network enrollees. For example, the 400,000 covered lives in the Minneapolis business coalition plan are self-insured, not prepaid — even though the provider networks and administration are provided by companies also licensed as HMOs.<sup>48</sup> Second, group and staff model HMOs historically and conceptually are the true HMOs. Group and staff model HMOs, however, only cover twenty million people. The IPA and other models cover thirty million people, but are not HMOs in a conceptual and traditional sense of the term.

## *2. Preferred Provider Organizations (PPOs)*

Preferred Provider Organizations were a major benefit innovation introduced in the early 1980s. Unlike HMOs, there are two levels of benefits in a PPO: a higher level when “preferred providers” or provider networks are used, and a lower level if other providers are used. PPOs are generally not regulated by the states, and were pioneered by self-insured plans unencumbered by inflexible HMO laws.

From an antitrust perspective, outside the few areas where HMOs have large enrollments, PPOs and their network successors were, and are, the principal engine of private reform because of their selective contracting with providers. Financing is predominantly self-insured, but also may be insured.

## *3. Point-of-Service Plans*

These are PPOs in HMO legal clothing, i.e., they are

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48. Interview with Fred Hamacher, Dayton Hudson Corp., in Phoenix, Arizona (May 14, 1996).

HMOs that offer a PPO-type two-tier benefit, so that patients at the "point-of-service" can go outside the HMO's closed panel.

#### 4. *Gatekeeper Plans*

Usually HMOs, these plans require patients to use a "gatekeeper" physician who must authorize referrals to other doctors, hospitals, and for other services.

#### 5. *Managed Indemnity*

Traditional indemnity plans allow free choice of doctor and hospital, regardless of cost, and require that hospital admissions and certain other services be pre-certified or "managed." "Managed Indemnity" plans are not network plans as the term is used here, since they do not selectively contract with or provide incentives to use a network of providers.

#### 6. *Self-Insured ERISA Networks*

Self-insured ERISA networks are defined here to be any health benefit program that is: (1) self-insured; (2) subject to ERISA; and (3) uses provider networks.

Networks are defined to be any arrangement between payers and providers that meets Judge Michael J. Melloy's test, that is, generates price as well as other forms of competition at the provider level.<sup>49</sup> As Judge Melloy decisively stated in *Mercy Health*, "[provider price] competition has occurred because of the arrival of managed care." PPOs and HMOs, which selectively contract with, own, or employ a limited panel of providers, are the classic examples of networks. Judge Melloy's Antitrust 101 point is often overlooked, but it is fundamental to antitrust law and to a market economy. In the words of the U.S. Supreme Court in a famous antitrust opinion, price is the "central nervous system of the economy."<sup>50</sup> Indeed, price competition is so important to a private market economy that it is a felony under federal and many state antitrust laws for competitors to "fix prices" by agreeing on price for the express

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49. *United States v. Mercy Health Serv.*, 902 F. Supp. 968 (N.D. Iowa 1995).

50. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n.59 (1940).

purpose of reducing or eliminating price competition.<sup>51</sup>

## VI. EXPLORING THE TWO ROADS OF MANAGED CARE

The Article at the outset explored a few of the implications of managed care's moving on two roads — a prepaid road and a self-insured road: one road represented by HMOs, the other by self-insured ERISA networks. Two implications were explored. The first is, *no premiums/no capitation*. If there are no premiums, where is the cash to pay capitation? The second is, *more regulation/more self-insurance*. That is, the more state regulators and legislatures try to regulate managed care, the more incentives they create for employee plans to become or stay self-insured ERISA networks to avoid government regulation.

This section explores some of the other features of the “two roads” of managed care.

### A. Private Versus Government Reform

For those who believe private markets responsive to consumers (patients) are superior to government command-and-control regulation, this is the best of times. For people of this world view, the superiority of private markets over government regulation is not a shock, it is simply to be expected.<sup>52</sup> At bottom, they have a revolutionary view: let the patient, not the government, decide.

For regulatory advocates, however, who believe that private markets and health care are oxymoronic, and that massive doses of state and federal regulation are “best” for patients,<sup>53</sup>

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51. One of the interesting differences between antitrust policy and some health policy analysts concerns “discount PPOs.” Since discount PPOs generate provider price competition, antitrust policy considers them to be an extremely important development. In some health policy circles, discount PPOs are given little, if any, importance.

52. See BREYER, REGULATION, *supra* note 4; see also SCHULTZE, *supra* note 4.

53. Rationing is perhaps the most extreme example. It involves “Grand Poobahs of Life and Death” deciding who lives and who dies — even though medical science is ever changing and often uncertain, and market forces are now often reducing costs. Rationing has long been a reality for the poor in some states. For many regulatory types, it is the only “rational” option for the future for all of us. See, e.g., Marilyn Chase, *New Prescription: Rationed Health Care Helps Oregon's Poor But Real Test is Ahead*, WALL ST. J., Mar. 22, 1994, at A1.



this is the worst of times. Today, they are either in denial, baffled by the stunning speed and success of private innovation in health care, or both. Indeed, like those who believed the world was flat, many are confident that private market innovation will soon fall off the edge of the earth.

#### B. The Challenges for the Next Generation of Managed Care

Health care is now poised to move beyond the "Model T" stage of managed care to the next generation. At the outset, the next generation is likely to be known by a more patient-friendly phrase than "managed care," perhaps "patient choice." There are many complex issues attendant to it.

The opportunities for the next generation of managed care are substantial, since health care has not yet solved the Blind Man and the Elephant riddle, nor mastered the Heisenberg Uncertainty Principle of Health Care, nor developed the appropriate financial incentives that reward providers for excellence without rewarding underservice or overservice. These subjects are discussed next.

#### C. The Blind Man and the Elephant

Health care in most cities suffers from the Blind Man and the Elephant problem. Doctors, hospitals, and other providers have practiced separately and independently for so long they see only their part of the elephant. Most providers do not, and cannot see the whole elephant, for claims processing, computer system differences, and other reasons. Even when providers and others want to collaborate, there is a babble of incompatible computer systems in doctors' offices, hospitals, employee health plans, and carriers, as well as antitrust risks that add to the complexity. There should be much opportunity for those who can remove the blinders.

#### D. The Heisenberg Uncertainty Principle of Health Care

Health care, like quantum physics, often is counterintuitive. The Heisenberg Uncertainty Principle of Health Care holds that low unit prices may result in higher total costs, and higher unit prices may lead to lower total costs and better

quality.

For example, a doctor may agree to a ten-percent discount and charge \$900 for a procedure in an area where the average fee is \$1000, but may employ the procedure three times more frequently than other doctors. As a result, the total *physician* cost will be \$2700, versus \$1000, and the *total* cost, including hospital and other services, even higher, despite a ten-percent discount on the physician's unit price.

### 1. Practice Variations and Scientific Uncertainty

Most people assume that there is a standard medical care treatment for any condition, based on scientific and proven treatments. For much of medicine, however, there are substantial and legitimate differences of opinion regarding treatment of a condition within the health professions. Often there simply is no scientific basis for distinguishing between risk, cost, and results. As a result, there are wide variations in the quantity or utilization of health care services delivered for comparable patients. As noted earlier, total costs can vary more than one hundred percent, depending on where people live.

Dr. John Wennberg of Dartmouth Medical School pioneered the study of these variations. Dr. Wennberg found, for example, that "[b]y the time women reach seventy years of age in one hospital market the likelihood they have undergone a hysterectomy is twenty percent, while in another market it is seventy percent."<sup>54</sup> That is, the variation in hysterectomy rates is more than 3.5 to one. Similarly, for men who reach age eighty-five, the percentage who have undergone prostatectomy ranges from fifteen to sixty percent, depending on where they live.<sup>55</sup>

These wide variations are not limited to hysterectomy and

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54. John E. Wennberg, *Dealing With Medical Practice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6, 9 [hereinafter Wennberg, *Dealing with Variations*]. See also WENNBURG ET AL., DARTMOUTH ATLAS OF HEALTH CARE IN THE UNITED STATES (1996); Philip Caper, *Variations in Medical Practice: Implications for Health Policy*, HEALTH AFF., Summer 1984, at 110; David M. Eddy, *Variations in Physician Practice: The Role of Uncertainty*, HEALTH AFF., Summer 1984, at 74; Howard H. Hiatt, *Will Your Next Hospital Stay Be Necessary?*, WALL ST. J., Nov. 18, 1986, at 36; John E. Wennberg, *Improving The Medical Decision-Making Process*, HEALTH AFF., Spring 1988, at 99 [hereinafter Wennberg, *Decision-Making Process*].

55. Wennberg, *Decision-Making Process*, *supra* note 54.

prostatectomy procedures. Dr. Wennberg found that "more than 85 percent of hospitalizations . . . appear to have greater variation in per capita use rates among hospital market areas than hysterectomy . . . ."<sup>56</sup>

These variations in medical opinions and treatment patterns also exist internationally.<sup>57</sup>

**Number of Admissions Per 1,000 Population**

<u>Country</u>	<u>Coronary Bypass</u>	<u>Hysterectomy</u>	<u>Prostatectomy</u>
United States	61	557	308
Canada	26	479	229
Japan	1	90	--
United Kingdom	6	144	144

Utilization, not unit pricing, is probably the most important challenge and opportunity for the next generation of managed care. The realities are that there are wide variations in utilization and professional judgment or practice patterns, as well as scientific uncertainty and legitimate differences of opinion on the efficacy of many treatments, and much is in flux. Utilization is far more intractable than unit price.

For example, a number of employers recently have advised me that according to their actuaries, their admissions per thousand patients should be sixty, but actually are more than twice that, 140 per 1000. They have tried insurance carriers, TPAs, and Utilization Review firms for years to manage utilization, but it is not working. Now, they want to try letting the people who treat patients, rather than a distant third-party computer program, nurse, or doctor try to manage cost and utilization.

56. Wennberg, *Dealing with Variations*, *supra* note 54, at 15.

57. Klim McPherson, *International Differences in Medical Care Practices*, HEALTH CARE FIN. REV., Supp. 1989, at 9, 14.

## 2. Variation by Location

The \$4000 average annual cost for employee health plans, however, is a true average. It varies substantially by age, location, and other factors.

As to location, total costs can vary more than one hundred percent depending on where people live:<sup>58</sup>

### Differences in the Total Cost of Group Health Plans by Location

<u>City</u>	<u>Factor</u>
Los Angeles	1.73
Miami	1.70
New York	1.39
San Francisco	1.34
New Orleans	1.23
Detroit	1.18
Philadelphia	1.16
Phoenix	1.10
Cleveland	1.08
Newark	1.07
Atlanta	1.06
Pittsburgh	1.02
St. Louis	.99
Denver	.95
Nashville	.95
El Paso	.89
Minneapolis	.88
Seattle	.85
Columbus	.84
Buffalo	.75
U.S. Average	1.00

Similarly, Medicare costs varied from \$2100 a person per year in one county to \$7800 annually in the highest-cost county—a difference of nearly four hundred percent!<sup>59</sup>

58. Miliman & Robertson actuarial data, cited in U.S. GEN. ACCT. OFFICE, EMPLOYER-BASED HEALTH INSURANCE 53 (Sept. 1992) [hereinafter GAO REPORT, INSURANCE].

59. See, e.g., AAPCC Ratebook, MEDICARE & MEDICAID GUIDE (CCH) ¶ 43,604 (Sept. 7,

### 3. Variation by Age

Total costs also vary substantially by age. There is, for example, a "4-to-2-to-1" rule of thumb for employee health plans: early retirees under age sixty-five (before Medicare eligibility) cost four times as much as persons over sixty-five (after Medicare eligibility), and twice as much as active employees.

#### The 4-to-2-to-1 Rule of Thumb

<u>Employee Health Plans</u>	
<u>Segment</u>	<u>Relative Cost</u>
• Regular Retirees (over 65) (Medicare Supplement)	1
• Active Employees	2
• Early Retirees (under 65)	4

### 4. Variation of Unit Prices

Total costs also often vary because of the wide variation in the unit prices charged for hospital and other services. The Pennsylvania Health Care Cost Containment Council has illustrative data on this phenomenon.<sup>60</sup> The following example shows that hospital prices varied by more than one hundred percent for the repair or replacement of a heart valve—with no correlation as to quality as measured by morbidity or mortality.

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1995). Similarly, Medicare costs for treating comparable patients vary from 21% below the national average in Rochester, Minnesota, the home of the Mayo Clinic, to 66% above the national average in Miami. Walter McClure & Dale Shaller, *Variations in Medicare Expenditures Per Elder*, HEALTH AFF., Summer 1984, at 120, 122.

60. Ron Winslow, *Data Spur Debate on Hospital Quality*, WALL ST. J., May 24, 1990, at B1.

### Repair Or Replacement Of Heart Valves With Pump and Cardiac Catheterization

Hospital	Average Charge	Number of Patients Who Died		Number of Patients with Complications	
		Observed	Expected	Observed	Expected
Allegheny General Hosp.	\$95,185	5	1.22	3	2.37
Presbyterian-University	73,209	4	1.30	2	2.36
St. Francis Medical Ctr.	66,993	1	0.40	2	0.65
Montefiore Hospital Assoc.	61,382	0	0.11	0	0.20
Shadyside Hosp.	51,809	1	1.60	0	2.78
Mercy Hosp. of Pittsburgh	48,559	1	2.08	4	1.89
West Penn Hosp.	44,959	1	0.91	3	1.50

Similarly, there should be much opportunity for those who understand and can master the Heisenberg Uncertainty Principle of Health Care.

#### E. New Provider Incentives

There are very important and difficult incentive system complexities: How do you reward cost and quality performance among thousands of independent businesses and solve the classic health care paradox of rewarding excellence, without rewarding either *underservice* or *overservice*?<sup>61</sup>

Judge Posner recently described the financial incentives for *underservice* in the HMO and capitated context: "The HMO's incentive is to keep you healthy if it can, but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and

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61. See, e.g., *Cover Story: The Soul of an HMO*, TIME, Jan. 22, 1996, at 44. See also MARC A. RODWIN, *MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* (1993), GEORGE CRILE, *SURGERY* 115-25 (1978) (stating that fee-for-service medicine creates a triple conflict of interest for surgeons).

cheaply as possible.”<sup>62</sup>

Dr. Arnold Relman, retired editor of the prestigious *New England Journal of Medicine*, has pointed out that there can be inappropriate financial incentives that lead to *overservice*:

[F]ee-for-service is piecework reimbursement and, like any piecework system, it provides powerful economic incentives to increase output — that is, to increase the number of services provided by physicians . . . . [T]he fee-for-service arrangement creates a conflict of interest for the physician. Although doctors are supposed to be agents and trustees for their patients, the economic rewards of fee-for-service provide incentives for them to recommend services that may not be necessary or cost effective.<sup>63</sup>

Properly aligning provider financial incentives with health care excellence will be one of the most important tasks and contributions of the next generation of managed care.

#### F. Contract Versus Ownership Integration

Today, health care is like many other technology-driven fields. Contract integration, not ownership integration, is the natural way most cutting-edge business is being conducted. In the words of Peter Drucker, the “dean” of American management consultants, “the greatest change in corporate structure, and in the way business is being conducted, may be the largely unreported growth of relationships that are not based on *ownership* but on *partnership*.”<sup>64</sup>

Drucker points out that in the 1950s the conventional wisdom was that by 1990 almost everyone would work for a big organization. “They were wrong,” Drucker states bluntly.<sup>65</sup> In short, Drucker sees the winners in the future as businesses that are masters of the “Network Society” of contract integra-

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62. *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995), *cert. denied*, 116 S.Ct. 1288 (1996).

63. Arnold Relman, *Cost Control, Doctors' Ethics, and Patient Care*, ISSUES IN SCI. & TECH., 1985, at 103, 106.

64. PETER DRUCKER, *MANAGING IN A TIME OF GREAT CHANGE* 69 (1995) (emphasis added) [hereinafter DRUCKER, *MANAGING*].

65. Peter Drucker, *The Network Society*, WALL ST. J., Mar. 29, 1995, at A14. *See generally id.*; PETER DRUCKER, *THE AGE OF DISCONTINUITY* (1968).

tion, not businesses locked-into the 1950's industrial model of vertical and horizontal ownership integration.<sup>66</sup>

In health care, well-known consultant Jeff Goldsmith came to the same conclusion. He points out that in 1980 many experts predicted that the industrial model of vertical and horizontal ownership integration would prevail in health care. He now abandons that view, and agrees with Mr. Drucker.

The core flaw in the integration movement in healthcare is the use of an obsolete, 19th-century, asset-based model of integration, in which accumulation of assets in a conglomerate style is assumed by itself to confer meaningful economic advantage.<sup>67</sup>

Another recent health care article, this one specifically on California's experience, also confirms Drucker's point that ownership integration generally should be the *last* choice, *not* the first choice of health care innovators:<sup>68</sup>

The legal and economic literature on firms and markets thus tends to view vertical integration as the governance mechanism of last resort, to be used only when market and contractual relationships are not feasible. This contrasts with the conventional wisdom in health services research, which apparently considers vertical integration as the governance mechanism of first resort under managed care.

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[T]here will be considerably more contractual relationships and considerably less vertical integration than predicted by some advocates of hospital-centered delivery systems.

Similarly, it has been reported recently that it is expensive for hospitals to acquire physician practices, but difficult to make these high-cost investments profitable.<sup>69</sup>

The substance underneath emerging post-"Model T" managed care includes addressing the unique facts and features of

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66. See U.S. FED. TRADE COMM'N, ANTICIPATING THE 21ST CENTURY: COMPETITION POLICY IN THE NEW HIGH-TECH, GLOBAL MARKETPLACE, ch. 10, *Joint Ventures* (May 1996).

67. *The Illusive Logic of Integration*, HEALTHCARE F., Sept. 1994, at 26, 28.

68. James C. Robinson & Lawrence P. Casalino, *Vertical Integration and Organizational Networks in Health Care*, HEALTH AFF., Spring 1996, at 8, 20, 21.

69. *Practices Sell, Hospitals Lose*, AM. MED. NEWS, Dec. 11, 1995, at 1.



health care, which may require and benefit from new forms of collaboration by small businesses, including physicians.

Total cost, not unit prices, is now the key to cost performance in health care. Yet most doctors<sup>70</sup> and hospitals are separate and often small businesses that have never collaborated among themselves or together to manage total costs and quality like typical businesses. As Judge Posner recently stated, "[p]hysicians practice in groups, in alliances, in networks, utilizing expensive equipment and support . . . . [Otherwise they] would be competing to provide horse-and-buggy medicine."<sup>71</sup>

Indeed, the next generation of managed care may be like other high technology organizations with a network of contractual rather than ownership relationships, for example, like Intel making computer chips:

The manufacturing discipline extends beyond the Intel factories. Equipment suppliers vying for orders from Intel are subject to painstaking scrutiny. Producers of chip-etching machines or furnaces, for example, will be put through runoffs judged by Intel that last months. One equipment maker will be chosen to supply Intel factories worldwide, reducing the chances of variation from one factory to the next. Because chip making is so precise, any variation is anathema, potentially reducing yields.<sup>72</sup>

Once selected, the supplier will be subject to even closer monitoring from Intel. It demands to know whether equipment makers want to use different subcontractors, even for screws and bolts, because any change could affect the manufacturing process slightly.

### G. Antitrust Relief<sup>73</sup>

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70. Remarkably, about two-thirds of the approximately 570,000 practicing physicians in the United States are either solo practitioners or in practice with only one other physician. AM. MED. ASS'N, *MEDICAL GROUPS IN THE U.S.*, 1993, at 43-44.

71. *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1412 (7th Cir. 1995), *cert. denied*, 116 S.Ct. 1288 (1996).

72. Steve Lohr, *Suiting Up for America's High Tech Future*, N.Y. TIMES, Dec. 5, 1995, at F1, F14.

73. See generally Charles D. Weller, *Antitrust and Health Care at the Crossroads: Dangers and Opportunities* (Nov. 1995 paper submitted to FTC Hearings) and Clark C.

Unfortunately, current federal antitrust policy is focused on "capitation," providers taking "substantial financial risk," and *Arizona v. Maricopa County Medical Society*,<sup>74</sup> with the result that an unnecessarily restrictive and actually anticompetitive antitrust approach is being applied to self-insured ERISA network plans and other settings where capitation is not being used or is unrealistic.<sup>75</sup> As happened with joint ventures several years ago, "uncertainties in enforcement policy have almost certainly blocked, delayed, or raised the cost of legitimate undertakings,"<sup>76</sup> for self-insured networks and similar plans.

It is also reminiscent of the cooperative price advertising disagreement between the Antitrust Division and the FTC in the early 1960s. The FTC took the position in an advisory opinion that joint price advertising was a per se violation, while the Justice Department's Antitrust Division disagreed. Specifically, the Assistant Attorney General in charge of the Antitrust Division wrote Senator Humphrey on April 19, 1963:

It is our opinion that the action of a group of small retail business concerns in publishing cooperative advertising containing selling prices does not in and of itself constitute a violation of the Sherman Act.<sup>77</sup>

Perhaps federal antitrust enforcers do not realize how successful they have been, and how much antitrust enforcement has contributed to the present private health care revolution. Perhaps they have been in battle so long and so hard that they

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Havighurst, *Are the Antitrust Agencies Overregulating Physician Networks?*, 8 LOY. CONSUMER L. REP. 78 (1995-96).

74. *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982).

75. For example, "pure" messenger models recently have been prescribed as a federal antitrust cure for provider network "price-fixing." The commonly used "modified" messenger model has not been so fortunate, hence it might be called the "impure" messenger model. In the real world, both models are totally impractical, very expensive, unnecessary, and are actually anticompetitive. To borrow a phrase, they are to competition in health care as military music is to music.

76. Robert Pitofsky, *A Framework for Antitrust Analysis of Joint Ventures*, 74 GEO. L. J. 1605 (1986).

77. See SELECT COMM. ON SMALL BUS., FTC ADVISORY OPINION ON JOINT ADS, H. R. Rep. No. 699, 88th Cong., 1st Sess. 25-32 (1963). See also Recent Developments, *Cooperative Advertising and the Per Se Rule* 16 STAN. L. REV. 1081 (1964) (discussing why the Rule of Reason applies).

have not had time to enjoy the fruits of victory. Or perhaps they, like many others, are victims of delayed reporting that has published little on self-insured networks, where there are generally no premiums and thus no capitation, but much on HMOs, where there are premiums and a long history of capitation and other forms of risk-sharing.

Whatever the reason, the dangers of current federal antitrust policy include the following.

First, it unnecessarily deprives the public of the full benefits of competition and innovation leading to the next generation of managed care, including full competition by provider networks to serve self-insured employee plans.

Second, it favors certain competitors over others (insurers, HMOs, and other third parties over doctors, hospitals, and other providers who actually treat patients, and ownership integration over contract integration). Antitrust policy should be neutral, so that the public can benefit from all forms of competition and the public, not government, makes the choices.

Third, with all due respect, the government will lose.<sup>78</sup> It is, of course, not good antitrust policy for the government to lose. Practically speaking, public and private antitrust plaintiffs who resort to the temptation of mechanistic antitrust, where anticompetitive effects are presumed rather than proven, generally lose.<sup>79</sup> Under the facts facing health care today and mainstream antitrust law,<sup>80</sup> bona fide physician, hospital, and other joint ventures that add value and have real customers will win.

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78. Two recent examples of the government losing are *United States v. Mercy Health Serv.*, 902 F. Supp. 968 (N.D. Iowa 1995) (denying injunction) and *FTC v. Freeman Hosp.*, 1995-1 Trade Cas. (CCH) ¶71,037 (W.D. Mo.), *aff'd*, 69 F.3d 260 (11th Cir. 1995) (denying preliminary injunction). Two landmark previous examples are *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974) and *United States v. Baker Hughes, Inc.*, 908 F.2d 981 (D.C. Cir. 1990).

79. *United States v. Baker Hughes, Inc.*, 908 F.2d 981 (D.C. Cir. 1990), is perhaps the most important example, since two sitting Justices of the Supreme Court (Thomas and Ginsburg) joined in an opinion that handed the government a stunning loss in this merger case. *See also United States v. General Dynamics Corp.*, 415 U.S. 486 (1974); *United States v. Morgan*, 118 F. Supp. 621, 688 (S.D.N.Y. 1953); *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992).

80. As Robert Pitofsky has observed, antitrust law is "all but unanimous that per se rules are inappropriate for joint venture analysis," that "[u]nlike cartels, joint ventures are devices that frequently achieve legitimate business advantages," with the result "that joint ventures in the United States generally have been treated leniently." Pitofsky, *Framework*, *supra* note 76, at 1605, 1606, 1621 (footnote omitted).

At the same time, there are great opportunities for federal antitrust policy, particularly now. Federal antitrust policy need only do the following.

1. *Include Self-Insured Plans.* Broaden the focus beyond capitation and risk-sharing to include self-insured network plans that have no premiums, no capitation, and no risk-sharing.

2. *Return Health Care to the Antitrust Mainstream.* Apply the same antitrust law used for *other* sectors of the economy to health care. FTC Commissioner Azcuenaga presented her views on "Integrated Joint Ventures," noting that capitation and risk-sharing were rather unique to the health care field and indicating that a simpler and more pragmatic approach to joint ventures was appropriate:

Instead of attempting to transplant the emphasis on capitation and risk-sharing from the market for physician services to other markets, it may be more useful to examine the market context in which the venture is being formed, including the likely market power of the venture. Although financial risk-sharing can be a key feature of an integrated joint venture, it may be easier in evaluating a joint venture in a new market simply to ask the more general questions posed by Judge Taft in *Addyston Pipe* or to explore as a matter of common sense whether the venture is reasonable for some purpose other than restricting competition. In short, I would warn against spending too much time examining the mechanics of how a joint venture is integrated and too little time considering the efficiency aspects of the venture and its significance to competition given the particular circumstances in which the venture is formed.<sup>81</sup>

There is no reason to treat health care any differently.

3. *Retire Maricopa.* *Arizona v. Maricopa County Medical Society*, a case from the horse-and-buggy era of health care, is being applied far beyond its legal, factual, and policy underpinnings. Meanwhile, 100 years of mainstream antitrust law, as well as current health care market realities, often are being ignored.

Mainstream antitrust law includes *Maricopa*, but is much richer and not limited to it. As Mr. Pitofsky has explained,

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81. Mary L. Azcuenaga, Joint Ventures — Finding the Safety Zone, Remarks at the American Bar Association Section of Antitrust and Section of Business Law, (Aug. 7, 1995), at 6.

*Maricopa* involved "little or no integration, no real improvement in the functioning of the market, and no increase in firm or group efficiency."<sup>82</sup>

The U. S. Supreme Court recently reemphasized, a decade after *Maricopa*, that "actual market realities," not "formalistic distinctions," generally are controlling in antitrust law.<sup>83</sup> In Professor Areeda's blunt terms about such joint sales agencies, "no one believes that they violate the per se rule against 'price fixing.'"<sup>84</sup>

The public would benefit, the times require, and mainstream antitrust law and policy fully support retiring *Maricopa* as the sole source of federal antitrust policy on provider networks before it further disables the private revolution under way in health care.

4. *Abandon Mechanistic Antitrust Law.* Heed the advice of the Supreme Court in *Broadcast Music, Inc. v. CBS (BMI)* that "price-fixing" "is not a question simply of determining whether two or more potential competitors have literally 'fixed' a 'price,'" and that "[l]iteralness is overly simplistic."<sup>85</sup>

[T]he blanket license involves "price fixing" in the literal sense: the composers and publishing houses have joined together into an organization that sets its price for the blanket license it sells. But this is not a question simply of determining whether two or more potential competitors have literally "fixed" a "price . . ." The Court of Appeals' literal approach does not alone establish that this particular practice is one of those types or that it is "plainly anti-competitive" and very likely without "redeeming virtue." Literalness is overly simplistic and often overbroad.<sup>86</sup>

5. *Apply Antitrust Joint Venture-Market Power Law.* Apply another area of mainstream antitrust law used for many sectors of the economy for many years, to the collaborations among providers and others in the health care field where there

82. Pitofsky, *Framework*, *supra* note 76, at 1617.

83. *Eastman Kodak Co. v. Image Tech. Serv.*, 504 U.S. 451 (1992).

84. PHILLIP E. AREEDA, 7 ANTITRUST LAW, ¶ 1510, at 422 (1986) (footnote omitted). *Accord* L. SULLIVAN, ANTITRUST 206-08 (1977); *National Bank Card Corp. v. Visa U.S.A., Inc.*, 779 F.2d 592 (11th Cir. 1986) (holding per se price-fixing rule did not apply to Visa, a horizontal joint venture, when it fixed an interchange fee and was lawful under the Rule of Reason).

85. *Broadcast Music v. CBS (BMI)*, 441 U.S. 1, 8-10 (1979).

86. *Id.*

are many independent professionals and entities. Mainstream antitrust in general, and joint venture-market power law in particular, provide sound bases for encouraging the collaborations that benefit the public, while preventing those that do not.

Health care is predominantly served by tens of thousands of independent, and proud, institutions and individuals, including doctors, hospitals, insurance companies, HMOs, PPOs, computer companies, and utilization review companies. Many are small businesses. Some will merge, but others will want to try to collaborate on some things, remain independent for others, and change over time. For the reasons detailed next, most provider collaborations will not have market power in the antitrust sense.

Mainstream antitrust joint venture law provides a sound legal and policy basis for federal antitrust policy and collaborations by doctors, hospitals, and others. Robert Pitofsky summarized mainstream joint venture law<sup>87</sup> in his opinion for the Commission in *In re Brunswick*:

The joint venture is in some respects a "quasi-merger," where cooperation between formerly independent companies often acts to benefit and spur competition. The combined capital, assets or know-how of two companies may facilitate entry into new markets and thereby enhance competition, or may create efficiencies or new productive capacity unachievable by either alone. As a result, relatively lenient merger standards usually apply to joint ventures, rather than straight per se rules that may apply to cartel behavior.<sup>88</sup>

There are two basic issues under joint venture-market power law. First, is this a bona fide joint venture, or after careful

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87. *Accord* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984) ("[J]oint ventures . . . hold the promise of increasing a firm's efficiency and enabling it to compete more effectively. Accordingly, such combinations are judged under a rule of reason, an inquiry into market power and market structure designed to assess the combination's actual effect.")

88. *In Re Brunswick Corp.*, 94 F.T.C. 1253, 1265-66 (1979), *aff'd in relevant part sub nom*, Yamaha Motor Co., Ltd. v. FTC, 657 F.2d 971 (8th Cir. 1981), *cert. denied*, 456 U.S. 915 (1982) (footnotes omitted). *See also* Pitofsky, *Framework*, *supra* note 76; Robert Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin*, 82 HARV. L. REV. 1007 (1969); Robert Pitofsky, *Proposals for Revised United States Merger Enforcement in a Global Economy*, 81 GEO. L. J. 195 (1992) [hereinafter Pitofsky, *Proposals*]; and Charles D. Weller, *Antitrust Aspects of PPOs*, in DALE H. COWAN, *PREFERRED PROVIDER ORGANIZATIONS* (1984).

review, a cartel? Second, do the parties have market power in the antitrust sense of the term?

6. *Measure Market Power Under Today's Realities.* Apply mainstream antitrust market power law to today's realities in the health care field. Today's market realities are that providers generally cannot obtain and maintain market power, and provider market shares generally will not translate into market power, for at least three reasons:

(a) *People.* People (professionals) are probably the most important resource for the next generation of managed care, and people, unlike plant and equipment in industrial markets, are legally and practically highly mobile;<sup>89</sup>

(b) *Excess Capacity.* There is considerable excess capacity in the health care field in terms of both facilities and professionals;<sup>90</sup> and

(c) *Managed Care.* The prevalence of managed care in most markets means that payers need not and will not accept anticompetitive arrangements.

A helpful analysis of today's market realities in over 3400 small geographic areas and 306 larger referral areas now is available, coincidentally and fortuitously. The *Dartmouth Atlas of Health Care in the United States* (1996), written by a team led by John E. Wennberg, M.D., M.P.H., of Dartmouth Medical School, shows the geographic distribution of hospital, physician, and other health-care resources in the United States in 3436 geographic "hospital service areas" and 306 "hospital referral regions."

It is basic antitrust law that market share does not automatically mean market power. Since provider market power will be rare or can be remedied easily, mainstream antitrust joint venture law provides strong support for encouraging bona fide joint ventures among providers and others to try to solve the many challenges facing the next generation of managed

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89. See, e.g., DONALD J. ASPELUND & CLARENCE E. ERIKSEN, *EMPLOYEE NONCOMPETITION LAW* (1995).

90. See, e.g., *Are Doctors A Dime A Dozen?*, HOSP. & HEALTH NETWORKS, Nov. 20, 1995, at 15 (discussing New Foundation study); Bill Richards, *Hold The Phone*, WALL ST. J., Jan. 17, 1996, at A1 (showing telemedicine broadens the geographic scope of physician practices).

care, without unnecessary antitrust impediments or risks.

7. *Low Entry Barriers/Service Shifting*. Under mainstream antitrust merger law, there are a number of methods of determining whether market power concerns can be extended to joint ventures. Mr. Pitofsky has summarized some of the applicable merger law as follows:<sup>91</sup>

Consistent with present enforcement agency guidelines and court decisions, mergers above the threshold levels would nevertheless be permitted where barriers to entry into the market were exceptionally low, where dominant firm behavior and coordinated interaction among firms left in the market is not feasible (for example, because products are extremely heterogeneous, making dominant firm or cartel behavior difficult to implement), or where similar products sold in other markets, or slightly different products, could easily be shifted into the merged firms' market if prices were to increase.

This suggests that three factors be applied to health care joint ventures, so that if any one of the three is present, the joint venture participants would know there is no antitrust market power concern:

- (a) barriers to entry are exceptionally low, or
- (b) dominant firm behavior and coordinated interaction is not feasible, or
- (c) similar services easily can be shifted if prices increase.

8. *No Purpose Except Stifling Competition*. It would be extremely helpful and procompetitive in these rapidly changing times to clarify when joint efforts by providers and others will be deemed joint ventures and thus outside the per se rule. To illustrate, the Department of Justice includes a mainstream antitrust definition of joint ventures:

A joint venture is essentially any collaborative effort among firms, short of a merger, with respect to R&D, production, distribution, and/or the marketing of products or services. For example, joint ventures may be created to take advantage of complementary skills or economies of skill and production, marketing, or R&D, or to spread risk.<sup>92</sup>

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91. Pitofsky, *Proposals*, *supra* note 88, at 201 (footnote omitted).

92. U.S. DEP'T OF JUST., ANTITRUST GUIDELINES FOR INTERNATIONAL OPERATIONS 41



Further, the case law suggests that a general rule applies, borrowing words from the U.S. Supreme Court: Joint ventures like any other collaborative activity are judged under the Rule of Reason and not under the per se rule unless they have "no purpose except stifling of competition."<sup>93</sup>

9. *Make Risk-Sharing Optional, Not Necessary.* As noted, federal antitrust policy at present is limited to capitation and risk-sharing for innovative providers to best avoid the per se rule, but is at best silent on market realities in most of the United States where there is little or no risk-sharing.

Once again, mainstream antitrust law can be used. The Supreme Court repeatedly has made it clear that risk-sharing is *not* a necessary element to avoid the per se rule (even though a price agreement by virtually 100% of the sellers and no risk-sharing was involved).<sup>94</sup>

The Antitrust Division also has made it clear outside health care that risk-sharing is one, but not the only, way of avoiding the per se rule in other settings. For example, the Department of Justice expressly lists risk-sharing as one of several alternative reasons for legitimate joint ventures. "[J]oint ventures may be created to take advantage of complimentary skills or economies of scale and production, marketing, or R&D, or to spread risk."<sup>95</sup> There is no reason not to apply the same rules to health care.

In summary, risk-sharing should be optional, but not a requisite, for bona fide joint venture status.

10. *The "Real Customers" Rule.* As a practical antitrust matter, as the 1993 Guidelines point out, it is "significant" if real customers request the joint action involved.<sup>96</sup>

Accordingly, a "Real Customers" Rule should be used as

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(Nov. 1988).

93. *Broadcast Music, Inc. v. CBS (BMI)*, 441 U.S. 1, 20 (1979) (BMI) (quoting *White Motor*) (emphasis added).

94. *Id.* See also *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 280 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899) (cited favorably in BMI, at 9).

95. ANTITRUST GUIDELINES FOR INTERNATIONAL OPERATIONS, *supra* note 92, at 41 (November 1988) (emphasis added).

96. See, e.g., U.S. DEPT OF JUST. & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN THE HEALTH CARE AREA 45 (Sept. 15, 1993).

one way to establish that a bona fide joint venture is involved. If at least one actual or prospective customer, such as an insurer, employer, health and welfare fund, HMO, or TPA, requests the joint activity, that should be sufficient proof that a bona fide joint venture is involved.

This simple, practical rule will have another salutary effect beyond reducing needless antitrust barriers to innovation. Health care, like any field undergoing turbulent change, has many interesting ideas for which there are no real customers today and no real prospects for the future. The "Real Customers" Rule also would lower health care costs and speed up innovation by focusing collaborative action on what employee health plans and other customers will buy.

11. *One Hundred Percent Market Share With No Exclusives.* The 1994 Guidelines use a twenty-percent market share limit for exclusive networks and a thirty-percent limit for nonexclusives. This is overly cautious in today's market and under established law. Most important, patients often prefer a wide choice of doctors and other providers. As a result, limiting patient choice to twenty or thirty percent of providers often will seriously reduce market appeal and likely success in the market, particularly in Type II managed care markets where self-insured network plans prevail.

Mainstream antitrust law and the new market realities in most of the United States permit and encourage provider joint ventures that even include all providers when they are non-exclusive. The Supreme Court in *Broadcast Music, Inc. v. CBS*,<sup>97</sup> with essentially 100% of the sellers involved, cited nonexclusivity in holding there was no per se price-fixing involved.

Finally, the facts in all or most of the United States are similar to one of the examples in the 1994 Guidelines that involved a joint venture with a large percentage of providers. Given those facts, the 1994 Guidelines concluded that anticompetitive effects were unlikely:

Although the joint venture has a relatively large market share of some specialties, it appears unlikely to present competitive concerns under the rule of reason because of three factors: (1) the

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97. 441 U.S. 1, 11 (1979).

demonstrated ability of health benefits plans to contract with physicians individually; (2) the possibility that other physician network joint ventures could be formed; and (3) the potential benefits from the coverage to be provided by this physician network joint venture. Therefore, the Agencies would not challenge the joint venture.<sup>98</sup>

In summary, health care joint ventures should be allowed to experiment with up to 100% of providers, so long as the provider arrangements, in practice, are not exclusive.

12. *Limit Oligopoly Price-Exchange Rules To Oligopolies.* A number of federal antitrust policy pronouncements apply oligopoly confidentiality rules to nonoligopolistic provider markets.

As a matter of antitrust law, rules limiting the exchange of pricing information by competitors were developed for oligopolistic markets. Most physicians and other providers, however, are in markets where there are many, rather than a few, competitors.

As a practical matter, it is very difficult if not impossible to be innovative and quickly respond to prospective customers in fast changing markets without access to all relevant information among independent providers, including unit prices and total costs. Health care consumers, providers, and payers would be greatly assisted by eliminating overly restrictive, impractical and unnecessary price confidentiality policies in most locations.

Again, given the shift to selective contracting in most of the United States, there is little competitive risk to allowing price exchanges among joint venturers and other collaborators. As the 1994 Guidelines point out, "any attempt by the joint venture's participants collectively to increase the price of physician [or other provider] services above competitive levels would likely lead third-party payers to recruit" providers elsewhere.<sup>99</sup>

Thus, federal antitrust policy should eliminate overly restrictive and impractical confidentiality requirements for health care providers, except in oligopoly provider markets.

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98. U.S. DEP'T OF JUST. & FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST 81 (Sept. 27, 1994).

99. *Id.* at 77.

13. *Provide Criminal Antitrust Guidance.* The Department of Justice has both criminal and civil antitrust enforcement authority. Criminal antitrust enforcement is the greatest risk to any individual or business in the health care or any other field.

Since the fear of criminal antitrust enforcement can chill innovation in the health care field unnecessarily, I suggest federal antitrust policy expressly:

(a) adopt the Antitrust Division's criminal enforcement policy;<sup>100</sup>

(b) limit criminal enforcement to per se violations;

(c) state that any person who complies with the Guidelines will not be subject to criminal enforcement; and

(d) encourage the states to adopt the same policy.

14. *Retire Regulatory Remedies, Use Antitrust Remedies.* Ever since the "messenger model" was invented in *Maricopa*, health care antitrust has been haunted by regulatory rather than mainstream antitrust remedies. Basically, mainstream antitrust remedies are self-executing, and require little or no ongoing agency or court monitoring or involvement. That is, the reconstituted market is the regulator, rather than government officials. Thus apply mainstream antitrust remedies, and abandon the temptation of regulatory remedies.

In conclusion, some or all of these changes to federal antitrust policy will provide a private market elixir with little risk of anticompetitive side effects for patients or the public.

15. *Provide Private Market Insight and Focus.* The reality is that there is widespread confusion and misunderstanding in health care regarding private markets and antitrust economics.

To illustrate, it is commonly and erroneously assumed in health policy circles that "big buyers" must exist for private markets really to work,<sup>101</sup> that patients are inherently incapable of making their own health care decisions, that legislation that "levels playing fields" usually promotes competition rather than hinders it,<sup>102</sup> that "cost shifting," rather than cost

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100. See Donald I. Baker, *To Indict Or Not To Indict: Prosecutorial Discretion In Sherman Act Enforcement*, 63 CORNELL L. REV. 405 (1978).

101. Under this theory, of course, the PC market could not exist, since there is no big buyer.

102. It is reported, for example, that some state insurance department regulators and some of

reduction, is the only option in private markets, that private markets always consolidate to two or three dominant firms, and that "HMOs are proxies for competition."<sup>103</sup> Clarification of how private markets really work is sorely needed and will stimulate further private health care reform that will benefit the public.

## VII. CONCLUSION

This Article has explored the factual reality that suggests that managed care is likely to evolve along two roads, not one road leading to HMOs. Conceptually, practically, and legally, the most important point of divergence between the two roads concerns premiums: the HMO/insured plan road has premiums or prepayments; the self-insured road does not. The Article finds that self-insured ERISA networks have the legal flexibility and numbers to lead, rather than follow, the move from the "Model T" to the next generation of managed care, perhaps to be known by the more patient-friendly and private market phrase, "Patient Choice."

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the regulated, including some HMOs, want to "level the playing field" by regulating their unregulated competition. See, e.g., *NAIC Bulletin to Address Application of Insurance Laws to Providers Groups*, HEALTH L. REP. (BNA), at 1177 (Aug. 3, 1995).

103. For a sampling of these and other subjects, see Charles D. Weller, *On "FTC Sings The Blues" and Its Respondents*, 7 J. HEALTH POL'Y, POL. & L. 547 (1982); Charles D. Weller, *On "Palm-Reading the Invisible Hand: A Critical Examination of Pro-Competitive Reform Proposals," (and Other Such Critiques)*, 7 J. HEALTH POL'Y, POL. & L. 295 (1982); Charles D. Weller, *Competition and the Cost of Hospital Care*, 258 JAMA 2064 (1987); Charles D. Weller, *Clarifying the Competition Strategy*, HEALTH AFF., Winter 1988, at 173.